Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DIPTI PATEL, D.C. 6660 AIRLINE DR. HOUSTON, TX. 77076	MFDR Tracking #: M4-10-0079-01
Respondent Name and Box #: WALMART ASSOC. INC. REP. BOX # 53	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary taken from the Table of Disputed Services: "Our facility obtained pre-authorization for these services"

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $716.80
3. CMS 1500
4. EOBs
5. Pre-authorization letter
6. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The health care provider billed for Work Hardening as opposed to Work Conditioning, which was approved…."

Principle Documentation:

1. Response to DWC 60
2. CMS 1500
3. EOBs
4. Pre-authorization letter
5. Medical records

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
12-15-08	97545-WH	39,5057,198,193,5170,	1, 2, & 3	$0.00
12-17-08	97546-WH (x5 units/hours)	& 5081	1, 2, & 3	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services* effective for services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason codes "39" (services denied at the time authorization/pre-certification was requested), "5057" (the healthcare provider requested preauthorization; however, the insurance carrier denied approval….), "198" (payment denied/reduced for exceeded precertification/authorization), "193" (original payment decision is being maintained-this claim was processed properly the first time), "5170" (the healthcare provider has exceeded the preauthorized services), and "5081" (reduction or denial of payment resulting after a reconsideration was completed).

2. In accordance with Rule 134.204 (h) (3) (A), the first two hours of the work hardening session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH."

3. A review of the original and of the request for reconsideration CMS 1500 forms identify that the work hardening program was billed; 97545-WH and 97546-WH. A review of the medical records submitted identify that the Requestor performed 'work hardening'. A review of the pre-authorization letter identifies that the original request was for the work hardening program. This request was negotiated and approval was for the work conditioning program only; total of 10 sessions to begin on 11-21-08 and end on 12-26-08. Being that the Requestor billed for the 'work hardening program', payment is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.204
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.